

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

=62-037514

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 4 Primary Registration District No. 5024 Registrar's No. 110

FILED NOV 13 1962

1. PLACE OF DEATH a. COUNTY <u>Atchison</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Atchison</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Polk Twsp.</u>		c. CITY OR TOWN <u>Watson</u>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>none</u>		d. STREET ADDRESS (If outside, give location) <u>Polk Twsp.</u>	
3. NAME OF DECEASED (Type or print) First <u>Virgil</u> Middle <u>Harold</u> Last <u>Frede</u>		4. DATE OF DEATH Month <u>11</u> Day <u>8</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>2-3-1913</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>	
11a. FATHER'S NAME <u>George Frede</u>		11b. MOTHER'S MAIDEN NAME <u>Dillie Barnhart</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		17. INFORMANT <u>Joseph Frede. Rock Port. Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SELF INFLICTED KNIFE WOUND TO THROAT</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)			
PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input checked="" type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20c. TIME OF INJURY Hour <u>1:00</u> p.m. Month, Day, Year <u>11 8 62</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>FARM</u>	
21. I attended the deceased from _____, to _____ and last saw her alive on _____		20f. CITY, TOWN, OR LOCATION <u>3 mi. East Watson</u>	
22a. SIGNATURE <u>J. H. Galley</u>		22b. ADDRESS <u>Rock Port Mo</u>	
22c. DATE SIGNED <u>11-9-62</u>		22d. LOCATION (City, town, or county) (State) <u>Watson, Mo.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>11-11-1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>High Creek Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Watson, Mo.</u>	
24. FUNERAL DIRECTOR <u>Bartholomew Mortuary, Rock Port. Mo.</u>		25. DATE RECD. BY LOCAL REG. <u>Nov. 11, 1962</u>	
26. REGISTRAR'S SIGNATURE <u>Thermin N. Schuler</u>		27. (Licensed Embalmer's Statement on Reverse Side)	

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

VS 300
Rev. 4/59

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Ernst Barthelme

Licensed Embalmer No.

3173

P. O. Address

Rock Pt. Me.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.